STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 87152-001**

v

Aetna Life Insurance Company
Respondent
_____/

Issued and entered
This 26th day of February 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 11, 2008 XXXXX, authorized representative for XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The matter was accepted on January 14, 2008. Aetna Life Insurance Company was notified of the external review and was requested to submit the information used in making its adverse determination. Aetna provided the information and documents on January 11 and 14, 2008.

The issue here can be decided by applying the terms of the certificate of coverage, the contract defining the Petitioner's health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner has health care coverage under a group policy with Aetna. She underwent

tests, treatment and surgery at the XXXXX from October 2006 through February 2007. XXXXX is not a network provider. Claims were submitted to Aetna which paid the claims at the non-network benefit level leaving the Petitioner responsible for charges totaling $9,347.60. The Petitioner appealed. Aetna reviewed the claims but affirmed its decision. A final adverse determination was sent to the Petitioner December 13, 2007.

III
ISSUE

Is Aetna required to pay more for the Petitioner's care at the XXXXX from October 2006 through February 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says she decided to have her surgery at XXXXX because she had been advised it was an in-network provider. In planning for the Petitioner's surgery, the Petitioner's authorized representative contacted the financial services/insurance sales representative for the employer's healthcare plan to determine if XXXXX was in-network. The representative, XXXXX of Upper Michigan Financial Services**,** states in a letter provided by the Petitioner that he was once told that the XXXXX as well as all other area clinics and hospitals were in-network and related this to the Petitioner.

The Petitioner says she would have considered another provider had she known XXXXX was an out-of-network provider. The Petitioner believes there has been gross misrepresentation with regard to XXXXX and their network status. She believes Aetna should provide coverage for her services at XXXXX at the network level of benefits.

Aetna Life Insurance Company's Argument

Aetna states that its Summary of Coverage on page 8 states, "To be sure that you will receive the full benefit available under this Plan, you should verify the provider's status by calling

either the provider or the toll-free number shown on your ID card." The certificate of coverage in the "Benefits Payable" section provides:

> Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a negotiated charge. See your employer for a copy of the Directory which lists these health care providers.

Services from non-participating providers require a $300.00 per person calendar year deductible. Eligible expenses are then paid at 70% of reasonable and customary charges. The Petitioner is responsible for charges in excess of the reasonable and customary fees in addition to any applicable deductible, coinsurance and/or copayment.

The glossary of the Petitioner's policy defines "reasonable charge":

> Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:
>
> - The provider's usual charge for furnishing it; and
> - The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
> - The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

Aetna asserts that their claim handling was consistent with the certificate of coverage.

Commissioner's Review

The Commissioner understands the Petitioner's unhappiness that she has incurred higher out-of-pocket costs than anticipated. However, in this external review the Commissioner is bound by the terms and conditions of the Petitioner's certificate of coverage.

While the Petitioner's plan covers non-network provider services, they are subject to a higher deductible and coinsurance. Non-network providers do not have contracts with Aetna. The plan provides benefits for covered charges to the non-network provider to the extent that the service or treatment doesn't exceed Aetna's reasonable and customary fee for that service. In addition to any required deductible and/or coinsurance, the non-network provider may bill for the difference between

the provider's charge and Aetna's reasonable and customary fee. Therefore, the insured can expect to have higher out-of-pocket expenses when receiving non-network services.

It is regrettable that the Petitioner apparently received incorrect information from Mr. XXXXX. However, the Commissioner does not have the authority to make findings of fact about disputes based on oral statements. Under the PRIRA, the Commissioner may only determine whether a claim was processed in a manner consistent with state insurance laws and the terms of the applicable policy or certificate of coverage.

The Commissioner finds that Aetna paid the Petitioner's claim according to the terms and conditions of Petitioner's certificate of coverage.

V
ORDER

The Commissioner upholds Aetna's adverse determination of December 13, 2007. Aetna is not required to pay more for the Petitioner's services from October 2006 through February 2007.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.